

# IMPLEMENTING THE CONTINUUM OF PREVENTION TO CARE AND TREATMENT IN PAPUA NEW GUINEA

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*Documentation of an experience in a  
resource-constrained setting*

*December 2012*

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Prepared by:

**FHI 360**  
**Asia Pacific Regional  
Office**

19th floor, Tower 3,  
Sindhorn Building  
130-132, Wireless Rd.  
Lumpini, Phatumwan  
Bangkok 10330.  
Thailand

Telephone:  
662.263.2300

**FHI 360**  
**Papua New Guinea**

Unit 3, Allotment 33,  
Section 38  
(P.O. Box 477)  
Steamships Compound,  
Waigani, NCD  
Papua New Guinea

Telephone:  
675.323.0966

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# ACRONYMS

<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ARV</b>	Antiretroviral Drugs
<b>AusAID</b>	Australian Agency for International Development
<b>BCC</b>	Behavior change communications
<b>BSS</b>	Behavioral surveillance survey
<b>CBO</b>	Community-based organization
<b>CHBC</b>	Community and home-based care
<b>CoPCT</b>	Continuum of Prevention to Care and Treatment
<b>CoPCT-CC</b>	CoPCT-Coordinating Committee
<b>FBO</b>	Faith-based organization
<b>FSW</b>	Female sex worker
<b>GIPA</b>	Greater Involvement of People Living with HIV/AIDS
<b>HBYP</b>	Helvim Bilong Yumi Project
<b>HCT</b>	HIV counseling and testing
<b>HIV</b>	Human immunodeficiency virus
<b>HRM</b>	High-risk man / High-risk men
<b>HRW</b>	High-risk woman / High-risk women
<b>IEC</b>	Information, education and communication
<b>KBW</b>	Kirap Bung Wantaim
<b>KLOM</b>	Komuniti Lukautim Ol Meri
<b>MARP</b>	Most-at-risk population
<b>M&amp;E</b>	Monitoring and evaluation
<b>MSM</b>	Man who has sex with men / men who have sex with men
<b>NAC</b>	National AIDS Council
<b>NACS</b>	National AIDS Council Secretariat
<b>NCD</b>	National Capital District
<b>NDoH</b>	National Department of Health
<b>NGO</b>	Non-governmental organization
<b>OI</b>	Opportunistic infection
<b>OV</b>	Outreach volunteer
<b>PAC</b>	Provincial AIDS Committee
<b>PE</b>	Peer educator
<b>PHO</b>	Provincial Health Office
<b>PLHIV</b>	Person living with HIV/AIDS / People living with HIV/AIDS
<b>PLWHA</b>	People Living With Higher Aims
<b>PNG</b>	Papua New Guinea
<b>PPTCT</b>	Prevention of parent-to-child transmission
<b>PSRC</b>	Peer Support Resource Centre
<b>QA/QI</b>	Quality assurance/quality improvement
<b>RIPA</b>	Real Involvement of People Living with HIV and AIDS
<b>SHP</b>	Strongim Hauslain Project
<b>SNF</b>	Sirus Naraq Foundation
<b>SOP</b>	Standard operating procedure
<b>STI</b>	Sexually transmitted infection
<b>TB</b>	Tuberculosis
<b>USAID</b>	United States Agency for International Development

# **1**//*INTRODUCTION*

***“Long before this ... I didn’t receive this kind of service. These kind of services were not available – referral, counseling and [community and home-based care]. We used to just come to the clinic and get our medications only without proper counseling and were left in the dark”.***

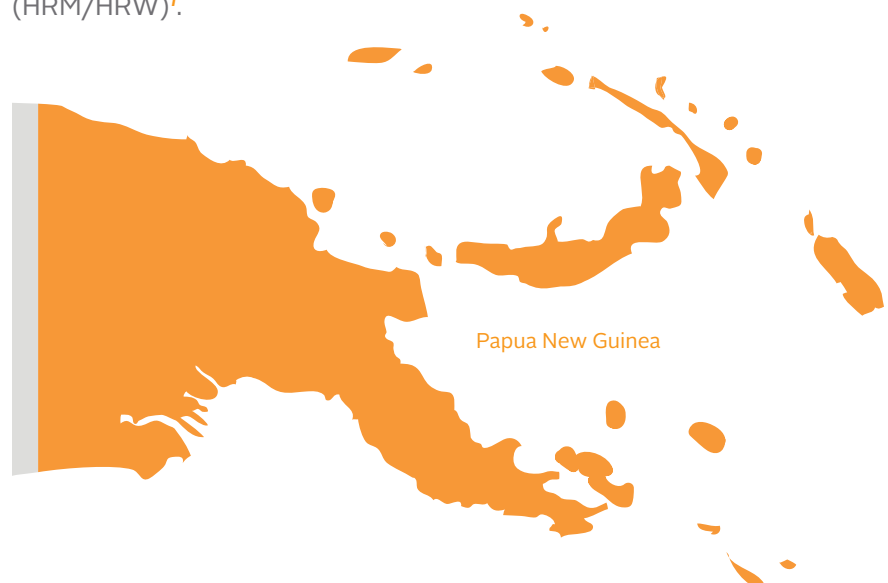
– “Kili”, case management volunteer, National Capital District

<sup>1</sup>Global AIDS Report (GAR) 2012: Country Progress report Jan 2010 –Dec 2012, Papua New Guinea UNAIDS

Kili (not his real name) is a case management volunteer who works with the Lawes Road clinic in the National Capital District (NCD) of Papua New Guinea. As an HIV-positive man, Kili understands well the difficulties involved in trying to access confusing and uncoordinated HIV service. However, as a case manager under the USAID/FHI 360-supported Continuum of Prevention to Care and Treatment (CoPCT) model, he is working to help ensure that patients today have a much easier time than he did. The CoPCT approach has been implemented successfully in other countries in the Asia-Pacific region. It has been used to develop systems to provide high-quality, comprehensive and continuous prevention and care services to members of most-at-risk populations (MARPs) for HIV infection as well as to people living with HIV (PLHIV) and their families. And a pilot test of the model in Papua New Guinea is demonstrating the impact CoPCT can have on strengthening prevention services, improving access to high-quality clinical care, and reducing loss to follow-up.

#### **// Epidemic Situation**

The current estimated HIV prevalence in Papua New Guinea (PNG) is estimated at 0.8% among 15-49 year olds in the general population, a four-fold increase since 2001. Recent evidence, including high prevalence of sexually transmitted infections (STIs) and widespread risk behaviors (e.g., unprotected vaginal and anal sex, multiple concurrent sexual partnerships, early age of sexual debut) suggest a concentrated HIV epidemic linked to most-at-risk populations including men and women who engage in transactional sex, men who have sex with men (MSM), and high-risk men and women who engage in multiple and concurrent sexual partnerships (HRM/HRW)<sup>1</sup>.



A behavioral surveillance survey (BSS) conducted by FHI 360 in 2010 among MSM and female sex workers (FSWs) in Port Moresby showed high levels of risk behavior and low levels of HIV knowledge. Key findings included that:

- » MSM had an average of 2.5 male partners and 2.1 female partners in the last month, while women had an average of 7.5 male partners in the last month
- » Heterosexual anal sex was extremely common (57% of women and 54% of MSM), but rates of condom use were low
- » 11% of MSM and 16% of women purchased condoms within the last month
- » Women's knowledge of HIV transmission focused on mother-to-child transmission; they had low levels of knowledge about the protective effects of condom use

An annual total of 3,200 HIV infections were reported in 2009, along with 1,300 AIDS-related deaths. HIV-related illnesses have become the leading cause of death at Goroka Hospital, while at Port Moresby General Hospital, 60 percent of the medical wards are occupied by AIDS patients and 20 percent of in-patients with TB are HIV positive.<sup>2</sup> The number of people requiring treatment is estimated to have increased from 3,204 to 9,061 between 2005 and 2009.<sup>3</sup>

As the epidemic shifts from HIV to AIDS, there is a need for both continued strengthening of prevention interventions and a renewed focus on the prevention of high-quality, coordinated care and treatment services, as well as social support, for PLHIV and their families.

## // The National Response

Papua New Guinea's national AIDS response has been overseen and coordinated by the National AIDS Council Secretariat (NACS) since 1997. Annual operational plans are guided by the National Strategic Plan for HIV/AIDS (2011-2015), which takes a 'back-to-basics' approach to improving the foundations of the primary health care system, with three key focus areas: **(1)** prevention; **(2)** counseling, testing, treatment, care and support; and **(3)** health systems strengthening. The government of PNG has achieved key successes in the fight against HIV, including strengthening involvement of civil society in the epidemic response, rolling out provision of HIV counseling and testing (HCT), and scaling up access to antiretroviral (ARV) drugs for treatment and prevention of parent to child transmission (PPTCT) services.

However, while the national response to the HIV epidemic in PNG has become more multifaceted and multisectoral, many gaps remain. As risky sexual behavior is driving the epidemic in PNG, one key gap is the need to expand and strengthen prevention interventions, and to move beyond raising awareness of the HIV epidemic toward addressing the psychosocial and structural barriers which prevent people from adopting preventative practices.

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<sup>2</sup>UNGASS Progress Report, 2008

<sup>3</sup>UNGASS Progress Report, 2010

<sup>4</sup>Green et al 2007; WHO 2008



Prevention interventions also function as a key gateway to clinical services, both by generating demand among target audiences and by facilitating uptake through service referral. While service coverage in PNG has improved, it remains limited – in the NCD region, the recent BSS found that only 26% of MSM and 33% of women engaged in transactional sex have been tested for HIV in the past year, and only 38 percent of PLHIV eligible for ART have access to treatment.<sup>4</sup> Meanwhile, services that do exist are under-resourced and exist in parallel systems with no strong referral linkages between prevention programming, testing services, and follow-on care and support or treatment services.

Most HCT sites and ART services in urban and peri-urban areas are critically understaffed. Counseling for adherence and partner notification and services for discordant couples and positive prevention are rarely available. Links between health services and community and home-based care (CHBC) services are underdeveloped or absent, and PLHIV are rarely involved in providing counseling and care. While many services are well linked at the provincial level, HIV services in primary, secondary, and tertiary levels of care such as within hospitals, between the community and hospitals, and among organizations working in the community are not. Many PLHIV describe difficulty in accessing a full range of services and consequently risk not receiving follow up.

Steps must be taken to ensure that those vulnerable to HIV are aware of their status and are able to adopt prevention strategies, and those living with HIV have access to HIV care and treatment.

## // A Continuum of Prevention to Care and Treatment

Services included in the CoPCT model include:

Prevention	Care and support	Treatment
<ul style="list-style-type: none"> <li>» Prevention package:               <ul style="list-style-type: none"> <li>-referral (STI, HIV counseling and testing, care and treatment)</li> <li>-condom and lubricant distribution</li> <li>-counseling for safer sex and partner reduction</li> <li>-peer outreach</li> </ul> </li> <li>» Prevention of parent to child transmission</li> <li>» STI management</li> <li>» Prevention with positives</li> <li>» Universal precautions/ post exposure prophylaxis</li> <li>» Addressing gender based violence</li> </ul>	<ul style="list-style-type: none"> <li>Home based care, which includes:               <ul style="list-style-type: none"> <li>» Client follow up</li> <li>» Adherence support</li> <li>» Palliative care</li> <li>» Peer counseling and support</li> <li>» Nutrition and hygiene</li> <li>» PLHIV support groups</li> <li>» Stigma reduction activities in community</li> <li>» Linkage and referrals to social services</li> <li>» Psychosocial and spiritual support</li> <li>» Legal issues</li> <li>» Income generation</li> <li>» Care for vulnerable children</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>» Opportunistic infection prophylaxis and treatment</li> <li>» TB/ HIV management</li> <li>» Antiretroviral therapy</li> <li>» Adherence counseling and monitoring</li> <li>» Palliative and supportive care</li> </ul>
<b>Cross-cutting activities</b> <ul style="list-style-type: none"> <li>» Promoting behavioral change communication interventions</li> <li>» Effective links between HIV services and family planning/reproductive health and other CoPCT services</li> </ul>		

The Continuum of Prevention to Care and Treatment model refers to a well-coordinated network that links and consolidates prevention, care and support, and treatment services to ensure a strong continuum of care for those at risk for, living with or affected by HIV. This model can be applied in any setting, and in resource-constrained settings can link to other private and non-profit providers, thus reducing the public sector burden while providing more comprehensive services to those in need. Home-based care teams can be trained to also provide services beyond HIV, alleviating suffering among clients with chronic diseases such as diabetes or terminal cancer.

In Papua New Guinea, the national government endorsed the launch of a CoPCT model through a joint assessment conducted by a team including PNG and US government agencies, international NGOs and multilateral institutions. Results of that assessment were shared at a November 2007 stakeholder meeting that included the National AIDS Council (NAC), provincial AIDS committees (PACs), the National Department of Health (NDoH), Provincial Health Office (PHO) and FHI 360/PNG. In order to establish the CoPCT, the NDoH and FHI 360 worked with local authorities in the National Capital District (NCD) and Madang Province, to review and finalize the gaps and areas that needed to be strengthened. Through consultations, training sessions and coordination meetings, FHI 360 then built and strengthened the capacity of health care professionals from selected health facilities, PLHIV support groups, NGOs, and faith based organizations (FBOs) to provide comprehensive, high-quality HIV/AIDS prevention, care, support and treatment services and referrals.

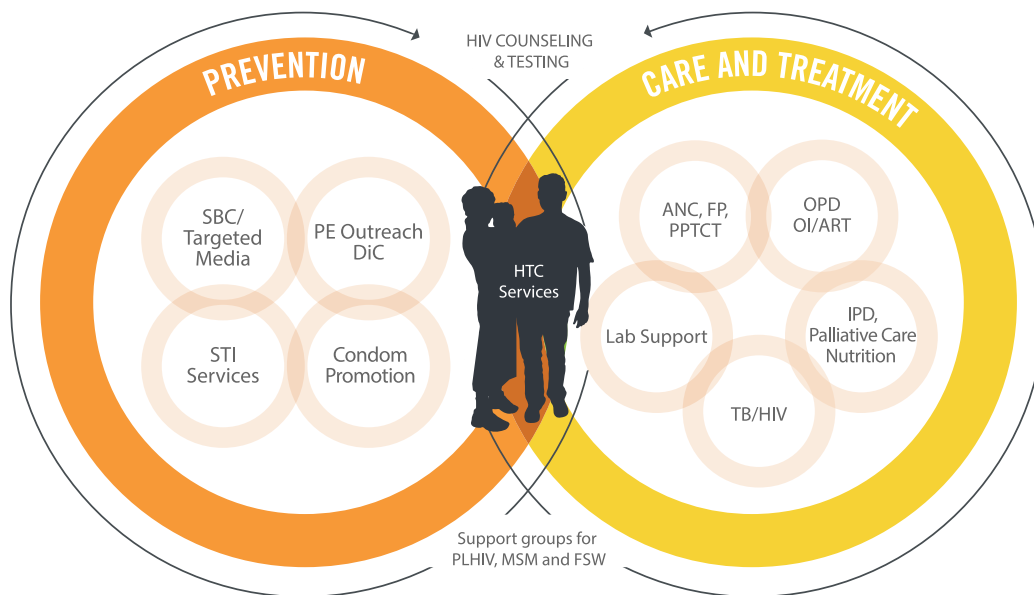
## // CoPCT in the PNG Context

In Papua New Guinea, the CoPCT approach augments the National HIV/AIDS Strategic Plan by strengthening partnership, coordination and service delivery at all levels. It increases the efficiency of service delivery and contributes to the overall plan and strategy in a manner that not only advances national HIV-related goals, but goals relating to other health and development areas as well.

The CoPCT is based on the following key points:

- » **Coordination** between public and private health facilities, PLHIV support groups, non-governmental organizations (NGOs), FBOs, other government offices (such as the Department of Community Development), and national and provincial AIDS councils
- » Strong **links and referral mechanisms** between the home, community and health care facilities
- » Active and **meaningful involvement of PLHIV** in all aspects of the CoPCT; and capacity building of PLHIV and their families to provide self-care
- » On-going **supportive capacity building and technical support** to ensure health care facilities provide quality care services
- » Strengthening of **monitoring and evaluation (M&E) systems** at the provincial and facility levels in order to generate information for action.

### Continuum of Prevention to Care & Treatment (CoPCT) Model



#### CoPCT COORDINATING COMMITTEE

FBO, CBO, NGO, PLHIV groups, community leaders, church leaders, CHBC team and other key stakeholders

#### Enabling Environment

Policy and Advocacy

Stigma and Discrimination Reduction

Community Mobilization

Strategic Information

Capacity Building

The CoPCT is comprised of two distinct but interrelated components: HIV prevention interventions and treatment, care and support services.

The prevention component of the CoPCT in PNG includes two distinct levels of interventions with different target audiences. The first level targets MSM and FSWs at locations, including bars and nightclubs, where people go to meet sexual partners (hotspots). The second level targets high-risk men and women within community settlements as part of the general population. Prevention activities are organized around the Comprehensive Package of Services model, and include several key interventions:

- » strategic behavioral communications conducted through peer outreach, individual and group counseling; targeted media and 'edutainment';
- » distribution of (male and female) condoms and water-based lubricant through one-on-one outreach and hotspot-based dispensers
- » Clinic-based HIV counseling and testing and STI screening and treatment
- » Effective referral to care and treatment services for those who test HIV positive.

The care and treatment component takes place within a facility (hospital and health centers and/or urban clinics) and in the community through home-based care providers, and focuses on the following key interventions:

- » Provision of interlinked essential services, including antiretroviral therapy (ART), diagnosis and treatment of opportunistic infections (OIs) and STIs, family planning and gender-based violence services, and psychosocial support.
- » Support for and referral to other clinical and social services such as palliative care, nutritional support, antenatal care and prevention of parent-to-child transmission services etc.
- » Trainings, mentoring and other technical assistance to provide laboratory support for clinical service providers

Prevention interventions are primarily linked to the care and treatment through HCT and STI diagnosis and treatment services. However, over the course of the project the two components of the CoPCT have become increasingly integrated as provision of care and support has been extended into communities and homes, and as prevention activities and messages have progressively been integrated into clinical components of the CoPCT.

Service provision under the CoPCT model is primarily the responsibility of a number of different organizations such as public sector health centers and clinics, private hospital and clinics, NGOs, FBOs, and PLHIV support groups. FHI 360 has provided technical and operational assistance including technical training, facility improvement, coordination, negotiation, and resource mobilization among various donors and stakeholders. Coordination of the CoPCT is the responsibility of the two provincial AIDS committees, the Madang PAC and NCD PAC, who work in close collaboration with their respective provincial health offices.

It is also recognized that effective provision of any services for MARPs or PLHIV is dependent upon the social and policy environment in which these services are implemented. The successes of the CoPCT model are thus underpinned by a series of overarching "enabling environment" interventions, which have included efforts to reduce stigma and discrimination through sensitization trainings for community and government leaders, clinical staff, police and private sector service providers; policy advocacy activities around decriminalization of high-risk behaviors and roll-out of new testing algorithms; and technical assistance and capacity building to assist local partners in strengthening strategic information systems.

### **// The Purpose of This Document**

What follows is an account of the development of the CoPCT model in Papua New Guinea, including the steps taken to establish coordination and referral systems among key partners, specific technical assistance provided to local service providers to build this model, and measures taken to ensure greater involvement of PLHIV in service delivery and to build acceptance of the model among local communities and stakeholders. A final section details lessons learned developing and implementing the CoPCT model.

It is acknowledged that the global discussion around prevention, care and treatment models is moving in the direction of monitoring these models to ensure HIV testing uptake (and case finding), successful referral into health and clinical systems and timely initiation of ART, and appropriate adherence monitoring and measures to avoid loss to follow up. In

order to contribute to that conversation, a companion document, CoPCT Process Evaluation, is offered in combination with this report. While this document outlines the necessary steps in establishing a Continuum of Prevention to Care and Treatment, the companion report presents a comprehensive analysis of quantitative and qualitative data, collected over 5 years of project implementation, to support the utility of this model.

The experiences of FHI 360 and local partners in PNG has shown that dedicated partners, with government support, can work together strengthening links and referral systems in a relatively short time. It is hoped that this document will generate additional support for continued implementation of the CoPCT in NCD and Madang, while also providing useful guidance for donors and implementing agencies wishing to replicate this model in other parts of PNG and beyond.

# 2//STEPS IN ESTABLISHING THE CoPCT

*The first step in developing the CoPCT was to assess the current needs, existing services and service gaps to establish what components of the model already existed but could be improved, and what components would need to be added.*

A joint team of NDoH/US government and other stakeholders<sup>5</sup> conducted a site assessment in 2007 in the NCD, Eastern Highlands (Goroka and Kainantu) and Madang provinces. Objectives of the assessment were to:

- » Map and review quality, coverage and sustainability of existing services (including ART services, laboratory capacity, existing PMIS and supply chain systems)
- » Identify service delivery gaps and determine which stakeholders would implement services to fill those gaps
- » Identify strategies to ensure effective linkages between all interventions and services
- » Report assessment findings and recommendations to the Government of PNG and key stakeholders

Key recommendations from the field assessment included the need to improve existing prevention, STI and HCT services and integrate prevention for positives into these services; strengthen quality of pre-ART and ART services; improve supply chain management for condoms and medications; increase involvement of PLHIV in service delivery; and strengthen collaboration and referral linkages between all partners. NCD and Madang province were selected as the first CoPCT sites. NCD is the national capital and has the highest population density, but the assessment found that available prevention and health care services were not part of an integrated system. Madang was selected over potential sites in the Eastern Highlands because funding limitations precluded the possibility of working in both sites, and while Madang had an existing service provider (Modilon Hospital) which was interested in receiving technical assistance, the site was not receiving the level of international assistance already available in the Eastern Highlands.

### **// Planning and preparation for implementation**

FHI 360 and its partners shared assessment findings

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<sup>5</sup>The team comprised representatives from the US Government (USAID and US CDC), Government of Papua New Guinea (NDoH, NAC Secretariat and PAC Secretariat), international organizations (FHI 360, WHO, Clinton Foundation, and UNAIDS), PLHIV support groups (PLWHA and Igat Hope) and AusAID.



Consultation with NCD governor, NCD Provincial AIDS Committee and FHI 360



Consultation with National Department of Health, STI/HIV Advisor and FHI 360

(see Appendix 1) through national and provincial stakeholder meetings and community forums which served to build awareness of and commitment to establishing a CoPCT model. FHI 360 also organized a study tour to review Cambodia's nationwide Continuum of Care model.

Formal agreement to launch a CoPCT was granted by the NDoH and NAC/PACs, and planning and consultation meetings were held with the NDoH, PAC Secretariat, PHOs and key stakeholders, including PLHIV. The planning process was participatory and focused on engaging, informing and motivating stakeholders.

In partnership with the local PACs and PHOs, FHI 360 hosted orientation workshops to inform and sensitize all partners at national, provincial and district levels, and to plan CoPCT activities. Continued consultations with PACs and PHOs and key stakeholders culminated in the establishment of the provincial CoPCT-Coordination Committees (CoPCT-CC) by PAC/PHO and FHI 360.

### **// Developing the network: creating coordination and referral systems in NCD and Madang provinces**

In order to bring together all the resources and services for PLHIV under one network, consultation meetings were held with PACs and provincial health offices in NCD and Madang to establish a CoPCT-CC in each of these two provinces (see Appendix 2 for more detail). The CoPCT-CC is responsible for:

- » Resolving coordination problems and improving referrals between services
- » Conducting annual joint planning for HIV services in each province, based on identified needs, gaps and areas of collaboration and coordination
- » Providing a regular forum for discussion of CoPCT-related issues
- » Helping to strengthen the involvement of, and partnership with, PLHIV groups

The CoPCT-CC has a diverse membership of public and private sector organizations, including government bodies (Madang-PAC, provincial health departments) and private companies (fisheries, transport companies, and hotels), health workers, PLHIV, NGOs, FBOs and community-based organizations (CBOs). The PACs are



the key provincial-level partners in coordinating the CoPCT and developing a referral network. Each PAC employs a local CoPCT coordinator; who, with technical support from FHI 360, coordinates with key stakeholders, promotes involvement of PLHIV and their families in all aspects of the CoPCT, and assists with strengthening referrals through development of tools, communication with service providers, and service monitoring.

### **// Establishing the referral network**

One of the key CoPCT strategies is to establish a strong and simple referral system both within and between hotspot- and settlement-based prevention interventions, community-based care and support services and the public and private health services system. The PAC and the CoPCT coordinator are the essential facilitators of a better referral system for MARPs, PLHIV and their families.

The CoPCT strengthened links and referral systems within the following areas:

- » **Hospital or health center:** between essential hospitals and/or health centers that include HCT, TB, family planning/reproductive health, ANC/PPTCT, in-patient department, laboratory and pharmacy
- » **Hospital/health center and the community:** between the essential hospital/health center services and community based services such as nutrition, family violence, and income generation
- » **Community:** between community-based services (including hot spot- and settlement-based prevention interventions and CHBC services) and HCT/STI and other clinical services.
- » **Private and government health-care services:** between private and government health-care services that provide care to people vulnerable to, living with and affected by HIV. Involving PLHIV in the system can lead to improved care and stronger referral systems.

## //Tools to support and improve the referral system

PACs, with technical support from FHI 360, developed tools to facilitate referrals:

### **Service information booklet**

Many clients and service providers are not aware of all the services available to PLHIV, MARPs and general population members. A consolidated directory of HIV-related care, treatment and support services under the CoPCT was developed to provide a profile of all available services offered through government health services, PLHIV groups, NGOs, FBOs and CBOs.

### **Referral cards**

These cards were developed by the CoPCT–CC to improve the referral mechanism between services at the provincial, district and community levels. Cards are distributed to clients through community-based outreach activities and provision of CHBC services. The cards are essential for tracking referrals between facility-based and community-based services, and vice versa.

### **Patient clinical booklets**

These are patient-held booklets that include a summary of all community-based and health facility services received, in order to provide a comprehensive record of the care received by PLHIV in each site. When reviewed by care providers in different settings, the booklets can lead to improved overall quality of care. Care providers summarize any referrals that were made within the booklets, and accompany these summaries with a referral card; clinical booklets therefore also assist in tracking referral uptake.

## // Establishing and/or strengthening existing services

### **Developing comprehensive care sites**

People living with HIV require a broad range of services including ART, treatment and prophylaxis for opportunistic infections, psychosocial support, adherence counseling and potentially other services. Instead of attempting to implement all services directly,

the CoPCT model emphasizes sustainability by working through the existing public health system to strengthen facility-based care and provide a broad set of prevention, treatment, care and support services through partnerships between health facilities, communities, NGOs, FBOs and CBOs.

NDoH and FHI 360 agreed to work collaboratively in strengthening facility-based services in NCD (9 Mile and Lawes Road clinics) and Madang (Id Inad Clinic, the ART clinic based within Modilon Hospital) and developed a joint work plan to establish comprehensive HIV care across the continuum and build health workers' capacity to provide high-quality HIV services. The work plan included establishing physical facilities with space for client consultation, counseling and support group meetings; personnel management plans with staffing and training requirements and supportive supervision systems; effective linkages and service promotion through prevention interventions; and improving logistical support for drug supply and laboratory/radiological services.

In addition, FHI 360 assisted facilities to develop clear client flow diagrams at the HIV clinics and provided direction on the use of medical forms, routine pre-ART and adherence



CHBC provision on Karkar Island, Madang



People Living with Higher Aims (PLWHA), community-based organization, provides CHBC in Madang Province

counseling, formation of case management teams, follow-up systems for patients (and facilitating links between the facility, community, and home) and in-service training to health providers and PLHIV.

NDoH supported these efforts by coordinating with all partners, mobilizing resources, training and providing supplies to the sites. NDoH and FHI 360 assisted in the development and/or revision of guidelines, strategies, and frameworks.

There have been key achievements under the CoPCT model in strengthening provision of clinical services for PLHIV, which have included increased number of patients initiating and adhering to ART at FHI 360-supported clinics, decreased loss to follow-up and decreased mortality. These achievements are discussed in detail in the CoPCT Process Evaluation report.

#### Building capacity of community and home-based palliative care services

The initial needs assessment conducted in NCD, Madang and Eastern Highlands provinces in 2007 found high prevalence of pain and other symptoms among PLHIV, and that they and their families experience significant emotional suffering. The assessment also found

high levels of stigma within communities and health facilities. As a result of the assessment, FHI 360 has worked with NDoH and others, under AusAID support, to establish community and home-based care services, as well as a national CHBC training curriculum and standard operating procedures.

Community and home-based palliative care is an essential element of the CoPCT model, which extends clinic-based care and support into the community and individual homes, ensuring that the continuum of care does not end when a patient leaves the hospital or clinic. CHBC also enables PLHIV and those with other chronic and life-threatening diseases to access health care services such as HIV counseling and testing, ART and OI treatment and prophylaxis, prevention of parent-to-child transmission of HIV, TB diagnosis and treatment and general health care. In addition, community and home-based palliative care helps other people in the community access correct information on existing health and social services and plays an important role in encouraging people to use these services. The *CoPCT Process Evaluation* report includes an in-depth discussion on uptake of CHBC services, and the role these services have played in strengthening clinical outcomes.



CHBC worker - Madang



CHBC workers and outreach staff - Madang

There are CHBC teams operating in the NCD, Madang and Goroka, established by FHI 360 with AusAID funding and in partnership with PLHIV groups, FBOs and NGOs. Each team consists of five members (one team leader, three team members and one health worker). PLHIV play a key role in provision of CHBC services and act as team leaders or members.

Teams are trained and equipped to provide PLHIV and people with other chronic diseases with ongoing care including management of pain and other symptoms; prevention, nutrition, and hygiene education; referrals to essential services; adherence counseling; emotional and spiritual support; care for affected children; and end-of-life care. FHI 360 and local partners provide on-going, supportive supervision and mentoring for CHBC service providers.

Community support groups made up of community leaders, teachers, social workers and religious workers have also been established. These groups assist in making referrals, developing linked services, conducting community awareness and/or education on HIV and promoting CHBC activities and/or CoPCT services.

To reduce stigma and discrimination at the community

level, CHBC services have educated, engaged, and built the capacities of PLHIV and PLHIV support groups; educated health providers and community members; and dispelled myths about HIV and AIDS. CHBC teams also provide care other chronic illnesses, thus avoiding the perception in communities that these teams provided HIV-specific services, which could have had adverse consequences for maintaining the confidentiality of CHBC clients and their families. Community health workers who have participated in training now understand HIV-specific issues and are capable of providing specialized care for PLHIV.

Community and home-based palliative care has also revitalized and complemented valuable cultural traditions in PNG: respect and care for the old and young and those sick or dying, as well the inclusion of grandparents, parents, children, aunties, uncles, and cousins in care.

At the same time, FHI 360 has worked with AusAID and local partners to maximize AusAID and USAID investments by integrating HIV prevention messages and materials into CHBC services. In the NCD, a mapping exercise was conducted in seven



*Outreach Volunteer demonstrating how to use a female condom*



*Outreach Volunteers demonstrating the difference between water based and oil based lubricants*

communities where the Hope Worldwide Helvim Bilong Yumi Project (HBYP) collaborates with the Sirus Naraq Foundation (SNF) to conduct joint prevention and CHBC activities, enabling greater outreach coverage among settlement-based HRW and HRM. In Madang, the Real Involvement of People Living with HIV and AIDS (RIPA) project distributes FHI 360-produced IEC (information, education and communication) materials during their CHBC activities.

### Strengthening prevention programming

When the CoPCT model was originally conceptualized, prevention programming was only loosely linked to treatment, care and support services and was largely focused on general population interventions. Beginning in 2010, FHI 360 and local partners began a major effort to refocus and strengthen prevention programming around a comprehensive package of prevention services for MARPs and other men and women whose behaviors put them at risk for HIV infection. These services include strategic behavioral communications and distribution of condoms and lubricant through peer outreach, individual and group counseling; targeted media and 'edutainment'; referral for HCT and STI screening; and assistance with accessing care and treatment for those who test positive. These interventions serve a number of key functions under the CoPCT model, including:

- » Promotion of safe and healthy sexual and gender norms through strategic behavioral communications, skills building and provision of resources and educational materials, including the FHI 360-branded I taim U: blotrupla man (With you: for real man) condom and lubricant package, and Risk Cards that deliver key messages on HIV risk and risk-reduction strategies
- » Creation of greater understanding of and support for MARPs issues among members of the general population
- » Strengthening of social support so that MARPs can access services without fear of stigma and discrimination, as for example through creation of peer networks and support groups in NCD and a Peer Support Resource Centre (PSRC) in Madang
- » Increased opportunities for people to learn their HIV status and, consequently, for positive individuals to access needed treatment, care and support services including counseling and support for reproductive choices and STIs; specific PPTCT interventions; early diagnosis; OI prophylaxis and treatment; palliative care; and access to ART
- » Provision of specialized sexual and reproductive health and maternal and child health services for PLHIV.





Outreach Volunteer talks about 1taim U condom package



Outreach Volunteers visiting the community

FHI 360 has strengthened this package of prevention services through training needs assessments, resources for implementation of best practices, and provision of standardized guidelines, standard operating procedures (SOPs) and technical mentoring. FHI 360 staff have worked with local partners to produce a number of outreach and communication tools, including risk cards, educational materials, and promotional items. When peer educators and outreach volunteers indicated difficulty in properly identifying and targeting MSM, male sex workers, FSWs, and high-risk men and women, a decision tree flowchart (see Appendix 3) was developed to facilitate more accurate identification of target populations by asking questions relating to sexual partners and risk.

Prevention interventions, which initially focused mainly on community outreach in settlements, were also split into community-based and so-called ‘hotspot’ interventions in bars and clubs, with the objective of focusing on HRM/HRW in communities while better targeting MARPs in hotspots where they meet sexual partners. Outreach volunteers (OVs) are permanently assigned to specific settlements, under the supervision of a

Field Support Officer, where they work to build a trusting relationship with members of the local community. Night interventions have been launched in the hot spots where MARPs are reached by peer educators (PEs) through one-on-one communication and ‘edutainment’ show. Implementation of the night interventions was complicated due to a lack of support among some venue managers; this challenge has to some extent been overcome, as detailed in the *Lessons Learned* section below.

Finally, formative assessment and other activities provided additional evidence for targeted communications for MARPs. This included design and implementation of the Trends (tracking exposure, knowledge and behaviors) module for routine data collection on intervention exposure, knowledge, and behaviors. Behavioral tracking data was used in the design of a communication strategy for MARPs with key behavior change messages (including HCT promotion) and activities designed for each specific audience segment. This communications strategy was specifically intended to move beyond raising awareness and identify specific barriers to and locally-relevant benefits

of behavior change. More recently, communication strategies have been expanded with support from AusAID to target mass media audiences through television and radio, and to expand to newer communication platforms including cell phone SMS and social networking media such as Facebook.

Properly identifying and reaching MARPs to provide prevention services has been a key challenge under the CoPCT model in PNG. Over the course of the project, significant progress has been made in standardizing operational

definitions of most-at-risk populations; while this has resulted in lower coverage overall, coverage of MARPs has increased in recent years in absolute terms and as a percentage of all populations reached with HIV prevention interventions. For a complete discussion, please see the *CoPCT Process Evaluation* report.

# 3//*TRAINING TO BUILD CAPACITY*



### **//Training to build capacity**

Strengthening of coordination and referral to broaden the range of services available to and accessible by PLHIV and their families has been a key milestone in the establishment of a CoPCT model in PNG. However, for the model to be successful, steps must be taken to ensure that the services promoted are of sufficient quality to meet clients' needs.

The initial assessment conducted in 2007 revealed that a comprehensive and wide-ranging training program was required to prepare service providers to offer effective care and support for PLHIV. The assessment also revealed there was a need to provide general information on prevention and control of HIV/AIDS, and the care and support needs of PLHIV, to a range of stakeholders. On-going training and mentoring to build capacity of service providers has thus been an integral part of planning and preparing for the CoPCT.

### **//Health facility-based capacity building**

FHI 360 in collaboration with the NDoH conducted in-service training for health workers on standard precautions, post-exposure prophylaxis, adherence counseling, STI

management and the use of standard operating procedures for managing OI/ART patients. FHI 360 also provided technical assistance in the establishment of the first Counselors' Network in NCD and Madang which meets on a quarterly basis. It is facilitated by the PAC care and counseling officer and helps support counselors to share experiences, receive updates on information related to counseling and HIV/AIDS, and seek support when needed. In 2009, the Momase Regional STI/HIV medical officer and FHI 360 established an HIV clinical response committee at Modilon General Hospital in Madang province. This committee comprises key staff in each hospital unit/ward (nurses and physician). It acts as a forum for staff to discuss problems and ideas, improve linkages between units/wards and to provide feedback to hospital management staff and to the CoPCT-CC. Regular meetings of the HIV clinical response committee within the hospital improved the coordination of HIV care between the various clinical units.

### **// Community-based capacity building**

FHI 360 has conducted a number of trainings to strengthen provision of community-based prevention and care interventions. These included:

- » Hotspot training and mapping exercises to identify venues where MARPs meet sexual partners and assistance to develop appropriate, targeted night interventions for those venues
- » Monthly refresher trainings for OVs and PEs on HIV risk assessment, correct use of condoms/lubricant, basic STI, HCT and post-exposure prophylaxis information, referral and follow-up for clients
- » Sensitization trainings for community leaders including government ward councilors, pastors, women and ethnic leaders
- » Community and home-based palliative care for CHBC team leaders and members (including training of trainers)
- » Self-care training for PLHIV and their care-givers
- » Training on adherence support and prevention with positives
- » Training on use of the decision tree to assist in better identifying target population members and provide relevant prevention information

For CHBC services, local nurses are paired with newly trained teams to build their capacity in care. This approach proved very effective in scaling-up CHBC services from the NCD to other provinces.

### **// Support and supervision**

Training alone is not enough for providers to be confident in their jobs. As part of the CoPCT, FHI 360 provides regular mentoring and supportive supervision to OV/PEs conducting settlement and hotspot interventions, CHBC teams, and clinical service providers addressing the specific needs of prevention workers, health clinic staff and hospital nursing staff and medical officers. Over time, these efforts have resulted in strengthened capacity and ownership within the government. While this process has taken time there is increased public and private investment in CoPCT activities which will contribute to the overall sustainability of this model. One example of this was the Lutheran Shipping Co. in Madang, which provided a vehicle to help CHBC teams reach communities and transport clients to the clinics.

# **4** *// INVOLVE PLHIV: PARTNERS IN LEADING, PLANNING AND SERVICE PROVISION*

***Greater Involvement of People Living with AIDS (GIPA) is a key UNAIDS principle, endorsed in 2001 by 189 United Nations member countries, which promotes the right of PLHIV to play an active role in the development of programs that concern them. Building collaboration with PLHIV is dependent on non-discriminating attitudes and the development of trust between clients and service providers. The involvement of PLHIV should be encouraged at all stages of the development and implementation of the continuum of prevention to care and treatment model.***

***// How are PLHIV involved in the CoPCT?***

Under the CoPCT model, PLHIV play major roles in the provision of HIV prevention education and HIV-related care, support and treatment, because they are the clients of those services and are therefore best-positioned to identify

their own needs. They conduct awareness raising and facilitate service referral through outreach and peer education activities. They provide health education on self-care, pre-ART and adherence counseling as members of case management teams at the HIV out-patient clinics. They are also active members of the CHBC teams that visit PLHIV within their

homes or in the community to provide a wide range of prevention, care and support services. Aside from these activities, PLHIV also participate as members of the CoPCT-CCs.

One example of PLHIV participation is the Kirap Bung Wantaim (KBW) network which translates to “Raise and Work Together”. The KBW network is an open meeting of PLHIV held at a regular time and place to encourage attendance from people traveling long distances; in general these are held on the days when ART patients collect their monthly medications. It is always held on the grounds of Modilon Hospital and Lawes Road Clinic. This brings PLHIV directly to services and facilitates the formation of positive relationships between PLHIV and hospital and clinical staff.

The KBW helps PLHIV discuss problems such as ARV stock outs and removal of settlements by government bodies, and helps identify resources such as homeless shelters in urban settings like Port Moresby. KBW also fills in gaps in the case of death among PLHIV in urban settings where the social fabric has been disturbed or has ceased to exist. House cry, a social custom for the deceased in Papua New Guinea, requires that support from relatives and



*Kirap Bung Wantaim PLHIV support group meeting*

extended families are extended in case of deaths – where PLHIV do not have family members to mourn them, KBW has helped to organize local PLHIV networks to fulfill this role.

Monthly KBW meetings are an opportunity for PLHIV and the health providers who work with them providing care and support to share experiences in an environment that stimulates teaching and learning. While the KBW network may appear at first glance to be primarily a strategy to provide care and support to PLHIV, it also reduces stigma and discrimination against PLHIV among health care providers and community members, as well as self-stigmatization among PLHIV.

PLHIV have also played an important role in raising awareness of HIV and facilitating referral to testing and other services. In Madang,

the People Living with Higher Aims (PLWHA) group worked with FHI 360 to establish a Peer Support Resource Centre where MARPs and other at risk men and women receive information about available services. A separate collaboration between FHI 360 and PLWHA, the RIPA project funded by AusAID, provides CHBC services in Madang. PLWHA also assisted in the organization and launch of the Karkar Friends Network (PLHIV support group) on Karkar Island in 2011. This group has now gone on to conduct basic HIV awareness raising in villages on Karkar Island and traveled to neighboring Bagbag Island where three of the PLHIV shared their experiences as PLHIV with others.

# 5// *CREATING ACCEPTANCE*

*PLHIV feel that stigma and discrimination in the community and at health facilities including Modilon Hospital is decreasing and is due to:*

- » Education of community leaders, ward councilors, other key stakeholders and community members; and*
- » Health services that provide effective care, thus enabling PLHIV to feel and look healthier.*

*— PLHIV support group from Madang*

Stigma and discrimination toward PLHIV, as well as toward MARPs, is widespread among health care workers and other service providers in Papua New Guinea and is a major barrier to increasing service uptake among PLHIV and MARPs. For instance, in a 2010 behavioral surveillance survey conducted by FHI 360 among MSM and FSW in Port Moresby, 32% of FSWs and 13% of MSM reported having been denied medical treatment within the last year, and 36% of FSWs said they avoiding seeking healthcare because of the stigma attached to selling sex.

Finding ways to reduce stigma and discrimination towards marginalized populations, and to increase acceptance of HIV prevention, care and treatment interventions for these populations, has therefore been an important part of the CoPCT model.

### ***// Developing services that are easy to use and access***

A notable success under the CoPCT model has been the elimination of perceived discrimination toward PLHIV from personnel at Modilon Hospital. PLHIV openly attend the hospital. They find the care they receive there is effective and of good quality and do not feel any discrimination from personnel. PLHIV use many common services and PLHIV inpatients are integrated into the general in-patient ward.

Much progress has also been made in reducing the self-stigma that PLHIV feel as their disease advances. PLHIV feel that the services to which they now have access have improved their health and allow them to be “just like everyone else.” Feeling and looking healthier, and having access to services, are critical to how PLHIV in Madang and some communities in NCD view themselves and how the community views them.

### ***// Involving families***

CHBC teams and staff at HIV clinics participating in the CoPCT provide capacity building to clients’ families to promote better understanding of HIV; increase knowledge about the benefits of ART and its side effects; provide information on self-care; and increase the ability of families to help PLHIVs manage their disease at home. This builds upon common PNG traditions that foster caring for the ill and dying within communities.

### // Mobilizing the community

Effectiveness and long-term sustainability of HIV prevention, care and support programs is dependent on broad involvement of both members of the target populations as well as the wider communities in which they live, work and access services. Numerous activities have been carried out under the CoPCT to mobilize members of the target populations, including support for an MSM/transgender network in NCD. Additionally, FSW support groups were established in the NCD and Madang to reduce stigma and discrimination and empower FSWs to access health care services and a Peer Support Resource Centre was established in Madang to guide MARPs to available services.

A key strategy to establish and build support for the CoPCT among service providers and in the wider community has been holding sensitization meetings on the CoPCT approach with local leaders, church leaders and other key stakeholders. The meetings provided information on the CoPCT and sought participants' cooperation in conducting prevention activities, promoting referrals, developing linked services and

supporting community home-based palliative care. In Madang, a fact sheet about the PSRC also has been developed to sensitize the general population and service providers about its services and the importance of prevention work targeting MARPs. And when hotspot-based night interventions were launched in the NCD, FHI 360 and local partners also established regular coordination meetings with venue owners to generate support for conducting prevention activities in those venues.

Finally, partners in the CoPCT have been active in larger-scale community mobilization interventions such as community awareness activities conducted in multiple sites in recognition of World AIDS Day and participation in mass media campaigns like HCT Week 2011. The “Banisim Wanem Samting Yu Laikim Stret” (Protect What You Love) campaign, funded by AusAID in 2012, targets the general population through television and radio spots and newspaper advertisements, as well as through community dialogue, to encourage partner reduction and condom use, as well as improved uptake of HIV counseling and testing.



# 6//*LESSONS LEARNED*

## ***The Continuum of Prevention to Care and Treatment model in Papua New Guinea evolved over a period of more than 5 years***

and was supported by the inputs of numerous agencies and technical experts. A full accounting of all the factors which contributed to the successes of this project model is beyond the scope of this report, but these are highlighted in a separate evaluation report. Nonetheless, for the benefit of other agencies, which may be interested in replicating the CoPCT experience in their own communities, below are a list of key factors, gleaned from discussions with project staff, without which the project would not exist in its present form.

### ***// Recognizing the power of partnerships***

PLHIV, their families, and individuals at risk of becoming infected with HIV require a broad range of prevention, treatment, and supportive interventions which include, but exceed, provision of traditionally-defined health care services and which must be delivered in a coordinated fashion across multiple facilities as well as in communities and private homes. It is acknowledged that no single organization or agency has the

capacity, resources or scope to delivery all necessary services for a truly comprehensive continuum of prevention to care and treatment interventions. Partnership is therefore at the core of the CoPCT approach. Although any list of partners will inevitably be incomplete, the success of this model in Papua New Guinea owes much to each of the following organizations: the NDoH, NAC, NCD and Madang PAC, Madang and NCD PHO, Modilon Hospital in Madang, PLHIV support groups, Hope Worldwide- HBYP, Friends Foundation, Sirus Naraq Foundation, Alternative Technologies Projects, FHI 360, and WHO. Many individuals, including community ward counselors, FBOs and community volunteers have also contributed to the success of the project.

Special mention should be made here of the importance of partnership with privately owned “hotspots” where individuals at risk of HIV infection seek sexual partners. These “hotspots” are key venues for reaching MARPs. FHI 360 established a core group of venue owners by holding

regular coordination meetings and being sensitized to business owners’ needs and concerns. Now some owners not only allow activities in their venues, they actively distribute IEC materials and condoms to their patrons and have requested prevention training for their own staff.

### ***// Building bonds between communities and clinics***

The perception (and, in many cases, reality) of stigmatizing attitudes and discriminatory treatment toward PLHIV and MARPs in many health care facilities in PNG has been a key barrier to increasing uptake of health care services. The CoPCT has demonstrated that it is possible to build willingness among health care providers for working with these populations, and this has been accomplished through desensitization training and by bringing together community members and clinical service providers through mechanisms like the Kirap Bung Wantaim network meetings. In Modilon Hospital in particular, the turnaround in health care providers’ attitudes toward PLHIV, and their expressed commitment to service provision, has been significant. KBW members have reported many positive changes in providers’ attitudes toward them.

### **// Helping PLHIV to help themselves**

One key strategy for reducing stigma and discrimination toward PLHIV in the healthcare system is by directly involving PLHIV in the delivery of healthcare services. In keeping with the GIPA principle, PLHIV have played an active role in shaping the CoPCT, from planning and coordinating as members of the CoPCT coordinating committees, to service delivery and monitoring as members of case management teams and as CHBC team members and team leaders. As a result of greater engagement with this community, PLHIV now openly utilize the government health services in the two satellite sites of Lawes Road and 9 Mile Clinic and at Modilon General Hospital. PLHIV project staff members have additionally reported reductions in internalized stigma: playing an active role in the epidemic response has bolstered their self-esteem, while enjoying better access to services has allowed them to improve their health and be “just like everyone else.”

### **// Using standardized tools for a data-driven response**

Particularly in resource constrained settings, it is imperative that limited HIV prevention, care and treatment resources be effectively targeted in order to deliver the most epidemiological “bang for the buck.” This requires effective monitoring to generate reliable data for intervention planning. However, at the outset of the CoPCT project, local partners faced challenges collecting and reporting accurate monitoring and evaluation data, and difficulty interpreting program results. In response, FHI 360 developed an M&E plan for the CoPCT and included in this plan is a list of all the program indicators designed to monitor progress in service provision. Based on this list, each service delivery site has a comprehensive, standardized set of tools for monitoring and reporting. These tools include HCT daily registers, first and follow-up health record forms for male and female STI patients, OI/ART registers as well as forms for laboratory tests and diagnosis, and a decision tree to guide appropriate identification of outreach contacts. Data were summarized on a monthly basis, and regular data quality assessments were conducted to ensure accuracy. Outcomes of establishing this system include clear reductions in loss to follow-up among OI/ART patients, and an outreach program that, while covering fewer individuals, concentrates its efforts more specifically on those most at risk of being infected.

### **// Monitoring not just quantity, but quality as well**

A successful CoPCT is concerned with not only how many individuals are provided services, but also with whether the services provided are of sufficient quality. FHI 360 has introduced quality assurance/quality improvement (QA/QI) checklists, developed in collaboration with various national and provincial stakeholders, to monitor service quality. These included OI/ART and HCT checklists, STI performance to standards tools, data quality checklists, and strategic behavior change checklists. FHI 360 staff also facilitated technical case discussions to resolve issues encountered. This QA/QI system helped to create a safe working environment for health care workers and improved services offered to clients. For instance, use of “performance-to-standards” tools increased internal examination during regular STI check-ups, expanded syndrome management and correct treatment, resulting in improved diagnosis and treatment of ulcerative and non-ulcerative STIs.

### ***// Behavior Change Communications (BCC) that moves beyond raising awareness***

One-size-fits-all approaches may raise awareness of the threat of HIV infection, but they are insufficient to promote adoption of prevention behaviors. For behavior change communication to be effective, prevention strategies, messages and materials must be targeted to the specific knowledge, beliefs, values and attitudes which drive behaviors in those populations at risk of becoming infected with HIV or spreading their infection to others. Specific steps taken under the CoPCT to strengthen prevention activities have included:

- » A culturally appropriate decision tree tool to aid prevention workers in accurate identification of different most-at-risk populations and delivery of appropriate information and behavior change messages
- » Behavioral tracking to identify barriers to change among specific target populations
- » Integration of tracking data into communications strategies segmented by population and driven by behavioral theory and marketing methodology
- » Targeting of specific risk populations in the places and at the times where they can best be reached with BCC messages

However, while prevention activities under the CoPCT are targeted to the specific needs of different populations, BCC strategies have also recognized that communities in PNG do not necessarily conform to or identify with broadly applied risk categories. Prevention interventions must take into account that, for instance, many women may engage in transactional sex without identifying as sex workers, and the majority of men engaging in sex with other men do not consider themselves to be homosexual.

### ***// On-going support for project staff and volunteers***

Project staff (whether peer educators, outreach volunteers, clinical service providers etc.) are neither interchangeable nor disposable. Experienced staff represent an investment of time, resources and institutional memory; where staff retention has been problematic, project activities have suffered as a result. While some turnover is naturally to be expected, staff should be supported appropriately, whether through salary, social benefits, and opportunities for self/professional advancement or some mix of these. Of particular importance under the CoPCT has been provision of regular opportunities for enhancement of professional skills through refresher and follow-on trainings, mentorship etc. Provisions should also be in place for re-training and supervision of newly recruited staff to ensure that project quality does not suffer in the event of unplanned turnover. Finally, provisions must be in place to ensure the security of project staff and volunteers, both when conducting outreach and service delivery (whether facility-based or in the field), and in terms of transport to and from project sites.

### *//Letting the community take the lead*

Community, from a public health perspective, has been defined as a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action. However, unlike in other settings, where there is a long history of organized community action, there is little evidence that a strong sense of community unites members of marginalized populations (i.e. MSM, sex workers) in PNG. Existing structures under the CoPCT model have successfully facilitated access to care and treatment for HIV-positive clients; however, this relative lack of community hampers efforts to organize and support community-based interventions which could provide the social support and context within which preventative norms are encouraged and at-risk individuals are empowered to remain HIV negative. Initial steps have been taken with support for organization community-building activities such as the MSM/Transgender network meetings and the FSW support groups; further measures should be taken to develop the leadership of these and other groups in order to foster a truly community-driven epidemic response.

While target populations in PNG do not necessarily identify with a community of MARPs as typically defined, specific communities do certainly exist in the PNG context, the support and buy-in from these communities will be crucial for further roll-out of the CoPCT model. In order to generate this support, programs and systems must be organized to meet the needs of communities, which requires basic systems strengthening, service integration and development of referral mechanisms to support the overall health system (and beyond). This may include, for instance, helping to provide support for potable water, basic health care services, and immunizations, as well as transport, security and personal safety, and other concerns. Communities will not support the CoPCT unless they feel this model meets their real, day-to-day needs.

# **7** // *THE FUTURE OF THE CoPCT IN PAPUA NEW GUINEA*

***The broad, collaborative nature of the CoPCT has resulted in a number of positive changes in access to services among PLHIV and retention in care. Since 2007, loss to follow-up rates for OI/ART at the Id-Inad Clinic in Madang declined from 13.6% to 1.4%.***

At the Lawes Road Clinic in Port Moresby, no loss to follow-up has been reported among current ART treatment patients; additionally, case management and client tracking at FHI 360-supported STI clinics in the NCD resulted in a reduction in loss to follow-up from 80% to 33%.

A broader perspective reveals signs of a strengthened health system. There has been greater involvement at the provincial level in planning and coordination of communicable disease epidemic responses (through participation in coordinating committees) and tertiary hospitals like Modilon General Hospital have become more proactive in seeking technical assistance in order to strengthen their own capacity. The establishment of coordination mechanisms has also helped clinicians to move beyond vertical thinking about diseases and begin identifying opportunities for integration with other areas such as reproductive health, family planning, TB and malaria.

There is also evidence of improved public trust in the health system in regions where the CoPCT is being implemented and where the health system and the community are working together. There are active partnerships between communities, the health system, and civil society.

Significant challenges remain, including training and retaining sufficient staff to coordinate and deliver high-quality services across numerous intervention areas. On-going security concerns hinder client access to clinical service centers and over the course of this project have resulted in several temporary clinic closings. Supply-chain logistics remains a key challenge – in 2012, the government faced a national-level stock out of one of the primary ART regimes. In this instance FHI 360 staff provided intensive mentorship for clinical staff members in partner agencies on delivery of the interim regimen recommended by NDoH in order to ensure the stock out did not affect ART provision at CoPCT sites.

Further steps must also be taken to fully engage faith-based organizations in CoPCT coordination and service provision, as these organizations provide health services for large proportions of the population in PNG.

Given that challenges remain to be surmounted, it is encouraging that the NDoH has expressed their support for replication of the CoPCT model in other provinces. However, financial commitments need to be made to replicate this model nationwide. The provincial health offices involved in the project have proposed to apply the community volunteers and outreach components of the CoPCT to other, non-HIV health services in urban clinics in the NCD and in Madang. While USAID funding for CoPCT services at the Lawes Road and 9 Mile clinics has ended, these services are being continued with funding from the NCD Health Office and the National AIDS Council Secretariat.

AusAID has provided funding to support replication of the CoPCT model in 2 additional provinces (most likely Enga and Western Highlands) over the next three years under the Strongim Hauslain Project (SHP). In NCD, SHP will focus primarily on CHBC and where possible will integrate MARPs interventions into the existing sites where Sirus Naraq Foundation is already providing CHBC services.

The AusAID-funded Komuniti Lukautim Ol Meri (KLOM) Project on reduction of gender-based violence will also use lessons learned under the CoPCT model to implement CHBC services in the Sandaun (West Sepik) and Western Highlands provinces.

Finally, services provided by Modilon Hospital in Madang will continue to be supported by FHI 360 under a new five-year project from USAID. The new USAID project grant also directs that the CoPCT model will be replicated with FHI 360 support in one new, to-be-determined province. In addition the new project will support provisions of services in 4 new clinics in the NCD, in partnership with the Salvation Army and Four Square Church. It is hoped that this document, along with the companion *CoPCT Process Evaluation* report, provides sufficient evidence to generate support for the further replication and roll-out of this model.



# APPENDIX 1

## CoPCT SITE ASSESSMENT RECOMMENDATIONS

### **Strengthen collaboration and partnership for CoPCT**

#### *At national level*

- » Introduce the CoPCT model to key stakeholders
- » Establish coordinating mechanisms through the technical working groups chaired by the NDOH/NACS
- » Fully integrate CoPCT into the healthcare system

#### *At provincial level*

- » Establish the CoPCT sub-committee within PACS
- » Map existing services
- » Develop/support linkages and formalize referral mechanisms (within hospital and among hospital, NGOs and community)
- » Incorporate CoPCT into community awareness/mobilization programs already underway

### **Improve treatment for STI**

#### *At facility and provincial levels*

- » Assess and facilitate improvements in the accessibility and acceptability of STI treatment services for FSW, MSM and PLHIV
- » Ensure adequate clinic capacity for STI treatment as ART patient load increases

#### *At all levels*

- » Support quality assurance/quality improvement for STI at all levels

### **Integrate prevention with positives into clinical, VCT and community-based services at provincial level**

### **Ensure that prevention messages move beyond awareness to behavior change at national and provincial level**

### **Support quality assurance/quality improvement process for HCT at the national level**

- » Develop SOPs for HCT services and review training curriculum
- » Evaluate the quality of HCT training and performance of counselors
- » Review accreditation process

***Improve the quality of counseling and testing services and improve access in targeted areas at provincial level***

- » Implement QA/QI for counseling (in line with national plan)
- » Facilitate accreditation process
- » Ongoing supervision, support and refresher training
- » Support and facilitate rollout of new guidelines for rapid test algorithm
- » Improve linkages between HIV testing and the full range of CoPCT services

***Support universal HIV testing for ANC attendees and formalize linkages to CoPCT services at national and provincial levels***

***Strengthen quality of pre-ART and ART services and promote integration of components at provincial level***

- » Ensure that all ART clinic sites are integrated into CoPCT networks for referrals and follow-up, especially as new ART sites roll out
- » Strengthen the team approach within the clinical setting in Modilon and Port Moresby General hospitals to improve coordination, collaboration and referrals between departments using the case management model developed at Goroka Base Hospital
- » Develop formal linkages between health facilities and the community (adopt a client-centered approach)

***Strengthen linkages between TB and HIV***

- » Joint strategic planning between TB and HIV programs at the national level
- » Increase HIV testing among TB patients and early TB screening among PLHIV at the facility level

***Support current efforts to improve logistics for supply chain management at both national and provincial levels for condoms and drugs for treatment of OI, ARV and STI***

***Increase coverage and range of home and community-based care services***

- » Work with national technical working group to train HBC providers on best practices model
- » Leverage existing community networks and support for services at the local level

***Strengthen the involvement of PLHIV in CoPCT at provincial level***

- » Develop new PLHIV support groups and/or strengthen existing groups
- » Enhance roles of PLHIV as the part of CoPCT (in HCT counseling, adherence support, CHBC, prevention (including prevention with positives) and income generation

***Strengthen implementation of national M&E system at provincial level***

- » Aggregate data at provincial level in addition to forwarding to national level
- » Support development of a data management plan (including hardware, software and human resource requirements)
- » Build capacity of DAC and PAC to effectively use data to guide the strategic plan and program implementation

### ***Strengthen data and capacity for QI of clinical services***

- » Build capacity of health care facilities for quality improvement by introducing HIVQUAL (a performance measurement and quality improvement approach developed by New York State Department of Health with U.S. HRSA support and adapted for international use by U.S. CDC in Thailand)

### ***Documentation of implementation of CoPCT***

- » Develop system to utilize routine data to monitor success
- » Document process for rolling out CoPCT sites and develop PNG-specific tools for scale-up
- » Disseminate reports and tools to relevant stakeholders in other provinces and districts
- » Utilize documentation data and experience from model projects to leverage funding for scale-up of CoPCT

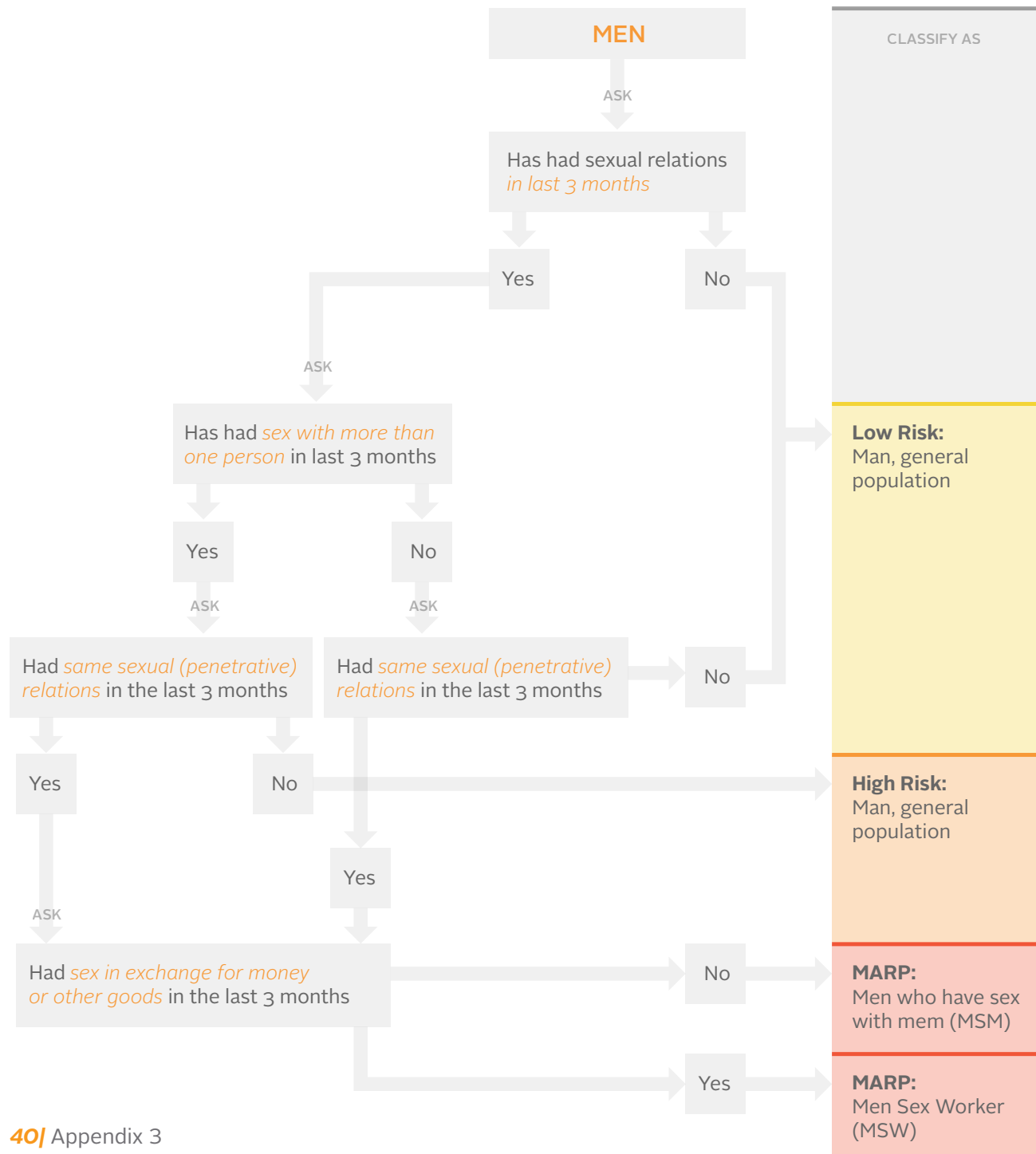
## APPENDIX 2

### *STEPS TO ESTABLISH A CoPCT COORDINATION COMMITTEE*

1. Conduct a consultation meeting with the PAC and PHO
2. Gain support and commitment from the PAC and PHO
3. Identify key people from relevant government departments (community development, education, health, legal affairs), health workers from the hospital, health centers and/or urban clinics, NGO, FBO and PLHIV support group and invite them to attend the first meeting
4. Conduct the first meeting to review the CoPCT-CC terms of reference, the current HIV situation, PLHIV needs and current services and gaps
5. Gain NAC's official approval of the committee including its purpose and membership
6. Establish a routine schedule for CoPCT-CC to address issues that help the CoPCT network run smoothly. Meetings should be minuted with action items and disseminated to all members in a timely manner so that action items can be addressed before the next meeting
7. Ensure flexibility to enable the addition of new members who can help improve services for PLHIV
8. Develop a schedule for distribution of invitations, agendas and minutes (at least two weeks before each meeting)
9. Set up an informal attendance register to identify people who may need encouragement from the CoPCT chairperson and/or coordinator to attend meetings

## APPENDIX 3

### DECISION TREE (MEN)



## APPENDIX 3 (2)

### DECISION TREE (WOMEN)

